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ABSTRACT

Contary to the impression one can derive from the large amount of mass media discussion, sex education is generally still not an integral part of the school curriculum. One of several important reasons for this state of affairs is that adolescents are usually not represented in discussions of the need for sex education. Even when sex education programs do manage to become operational, the lack of teen input often results in such flaws as (1) having sexual physiology taught without being related to the psychosocial aspects of human sexuality, (2) avoiding controversial topics adults are uncomfortable discussing, and (3) conducting separate classes for males and females. The consequences of limited sex education are unwanted pregnancies and an epidemic level of venereal disease, along with ignorance and misinformation about sex which worries teenagers themselves. Teen input can help overcome such deficiencies. Adolescent representation in the planning and operation of a teen contraception clinic is also useful. Teen input insures that users of the service will not feel alienated by the program and contributes to teenagers' maturity by teaching them how to handle responsibility. (Author/CD)

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UNDERREPRESENTATION OF ADOLESCENTS IN EDUCATION AND HEALTH CARE PLANNING

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A healthy adolescent has two eyes, two hands, two feet and the neurological and muscular systems necessary to coordinate their functioning. On even the first try, any such person can get behind the steering wheel of an automobile and drive it away, albeit with varying degrees of success. Nevertheless, having analyzed the serious consequences of poor driving, we have for years been teaching driver education in the public schools. Even though we have recognized that the best way to become a responsible driver is not by trial and costly error, we seem reluctant to reach this conclusion in the context of becoming a responsible sexually active person.

As a result, we are years behind in making sex education an integral part of the school curriculum. That last statement may sound strange given all the rhetoric and media attention concerning sex education, but sadly, it is true. Although there is a lack of data based upon representative national samples, the evidence which is available indicates that far less than half of our high schools have any sort of population education. Even in those schools, the courses are estimated to reach only an average of 11.4% of the students. Approximately half the teachers dealing with this subject include some material on human reproduction and sexuality and about the same proportion include some information on fertility control techniques (Gustavus & Huether, 1975).

This situation appears to be the result of several factors. First, the political Zeitgeist is not as liberal as one might assume.

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For example, a year ago (January, 1975) the Chicago Board of Education approved a plan to broaden sex education in the public schools. This plan allows for expansion of a school's sex education program if school officials obtain the support of parents, the Parent-Teacher Association, and the local School Community Council. Having obtained approval from all of these groups, then, for the first time, teachers would be allowed to answer questions about birth control, abortion, homosexuality, masturbation, and venereal disease. Not exactly a trailblazing position for one of the nation's largest school systems. In light of the results of public opinion polls which show that Americans firmly support sex education in the public schools (Lipson & Wolman, 1972; Blake, 1973), this appears to be a case where a vocal minority has imposed its will on a silent majority.

A second factor is that unlike driver education, we have typically paid little attention to the negative health and social consequences which can result from uninformed sexual activity. In the case of adolescents, these consequences usually take the form of venereal disease and unwanted pregnancy. Venereal disease, and its various outcomes ranging from embarrassment to death, is epidemic throughout the population and especially among adolescents (Center for Disease Control, 1975b). Nonmarital adolescent conceptions are also widespread and are resulting in large numbers of hasty marriages (National Center for Health Statistics, 1970), illegitimate births (National Center for Health Statistics, 1975), and abortions (Center for Disease Control, 1975a). The pervasive detrimental health and social effects of teenage childbearing are well-documented and run the gamut from higher than average maternal and infant morbidity and mortality to restricted development of the personal, social, and eco-

nomic potential of the parents and child (e.g., Menken, 1972). As Figure 1 illustrates, with nearly one out of every five U. S. births

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Insert Figure 1 about here

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being to a mother less than 20 years old, the American situation is in great need of improvement.

A factor related to the lack of attention directed to the consequences of uninformed sexual behavior concerns the antiquated notion that sex is the one aspect of human behavior where no education is necessary -- where the requisite knowledge is somehow innate. This is the sex as instinct school of thought as popularized by Freud. We now realize that this is a very narrow view and that human sexuality is largely acquired behavior. As the most cerebral animal, man is primarily a psycho-socio-cultural being whose conduct is less biologically or instinctively determined when compared with other animals.

Teenagers themselves are very aware of their own needs for knowledge in this area. For example, a study I conducted at a Detroit Planned Parenthood Teen Clinic revealed that only 11% of the young men and women (N = 1190) who attended sex education rap sessions knew as much about birth control as they wanted to know. Unfortunately, programs designed by adults in the absence of teen input often wait until it is too late (such as after an abortion, a forced marriage, or the birth of an illegitimate child) before providing needed contraceptive education and services.

This reluctance to provide needed programs is often based upon the belief that such programs will cause sex behavior. However, those of us who have been involved in promoting the representation of teen-

agers in sex education and sexual health care planning have accumulated evidence which shows that such a belief has no basis in fact. For example, a large majority of the almost 1,200 teens queried at the Teen Clinic had three things in common: (1) as noted previously, they wanted to know more about birth control; (2) they wanted to obtain birth control; and (3) they were already sexually active. In other words, there is no relationship between knowing as much as one would like about birth control and having had intercourse ($X^2 = .32$, $p = .85$). Contrary to the old myth, one does not acquire all the knowledge one desires by merely losing his or her virginity. This was shown half a century ago by the pioneer studies of the sexual conduct of individuals which revealed people involved in a struggle to work out their sex lives while in an environment of ignorance and isolation (Davis, 1929; Dickinson & Beam, 1931). In the light of a conservative estimate of 705,000 conceptions by unmarried teenage women in 1973 (Vadies & Pomeroy, 1974), it is obvious that a lack of information and access to contraceptive services is not a deterrent to nonmarital teenage sexual activity. After the American experience with Prohibition, this should not come as a surprise to anyone.

A second problem which often occurs when there is a lack of teen input into sex education programs is that of having the physiology taught without its being related to the psychosocial aspects of human sexuality. Sex education then ends up being taught like a cut and dried electronics course complete with schematic diagrams, even though it deals with the most emotion-laden segments of human behavior -- sex, reproduction, and family life. Attitudinal topics are often avoided, although adult planners, especially those whose views of teenage sexuality have been heavily influenced by the mass media, might be quite surprised at some of the opinions expressed by teenagers

As an example, consider the attitude data presented in Table 1 which was obtained from a knowledge, attitudes, and practices ques-

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Insert Table 1 about here

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tionnaire completed by the Detroit teens before they attended the sex education rap session (details of the methodology and a complete discussion of the knowledge results may be found in Reichelt & Werley, 1975a, 1975b). Half the teens (49%) felt that girls are often talked into having sexual relations, and only 5% felt that it is a social disadvantage to be a virgin. The mass media would often have you believe that the teenaged virgin is a social leper who belongs on the Endangered Species List.

Teen input, in terms of attitudinal data such as this, is not only useful in helping insure that the psychosocial aspects of human sexuality will be included as programs are developed, but is also a great aid as a discussion starter. Adolescents are both worried by pluralistic ignorance of sexual knowledge (e.g., is masturbation normal) and extremely interested in the opinions of their peer group. As a discussion opener, consider the item concerning the definition of virginity.

Reporting the results back to the teens will typically evoke discussion which brings to light two opposing viewpoints. The majority view, which accepts the technical definition of virginity, and a more recent view which senses hypocrisy in such a definition and argues that there is little meaningful difference between sexual intercourse and such activities as mutual masturbation. This can lead to an illuminating discussion of what sexual behavior means to the teenagers.

In order to promote open discussion between the sexes, it is hoped that sex education programs will discard the old practice of segregation. When both sexes are present, feedback of the data, broken down by sex, can be useful so that each sex can become aware of the other's viewpoint on the issues under discussion. For example, in the present case, more females than males felt that girls are often talked into having sex. Delineation of this sort of perceptual difference is quite useful in helping the teens come to grips with their own and with other's feelings concerning sexuality.

When reviewing the attitude data presented in Table 1 it should be noted that the responses to each item are broken down into the three categories of "True", "False", and "Don't Know". This simple threefold response scale was chosen in order to accurately reflect the teens' opinions without resorting to the use of a more cumbersome rating scale. It is often the case that when members of one group (in this case adults) view the members of another group (teenagers), they tend to describe them in black and white terms which is generally an oversimplification. For example, on the item concerning male fear of sexually experienced females, a third (31%) of the teens expressed no firm opinion. Those of us who would plan and conduct sex education programs need input from teens in order to remind us that we are dealing with opinions which are in a state of formation and flux.

In regard to the three-part response scale, it should be mentioned that this response format has also been found to be very appropriate for obtaining teen input concerning their knowledge in the area of human sexuality. Because sexuality has, until recently, not been a topic for open discussion, it is an area which is full of

myths and half-truths. Thus, it is very important to distinguish between the lack of information and misinformation. This is because misinformation is more apt to consistently result in inappropriate behavior than is a lack of information. When information is lacking it is sufficient to provide the missing knowledge, but when misinformation is believed true, one must dispel the myths before providing the correct information. And to determine what the current myths are among the population to be served, teens from that population must be represented in the planning process. Among the Detroit area teenagers, for example, a current belief was that condoms broke easily, but this myth is not as strongly believed in by other teen populations.

A third negative consequence of the underrepresentation of teenagers in the program planning process is a tendency to avoid controversial topics, especially those which the adult planners are uncomfortable in discussing. Oral sex is one example of such a frequently avoided topic, and yet, as the data presented in Table 2 re-

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veal, over half of the teens studied had engaged in oral-genital sex. (The small percentage listed in the "Don't Know" column are assumed to represent teens who are unsure of the definition of oral-genital sex.) That this degree of participation in oral sex is not atypical is confirmed by other reports (Physicians International Press, 1972) and by laboratories' increasing clinical responsibilities to detect gonorrhea in throat cultures (Brown, 1975). In addition, these data indicate that an even larger majority of the teens can be expected to participate in oral-genital sex in the future. The items presented

in Table 2 are a combination of knowledge, attitude, and behavior. However, it should be apparent that the comments previously made in regard to the possible uses of the attitude items concerned with the psychosocial aspects of human sexuality are equally applicable to this set of items.

Adolescence is a time of transition -- a time of increasing emotional maturity and of learning to handle new responsibilities. Emotional maturity is actually a process of growing self-awareness and a well-run sex education program can and should be an important part of this. For example, until the adolescent is emotionally ready to deal with the possibility of pregnancy, it is not seen as real and thus is not a threat. Sexuality is primarily a personal issue for which individuals must take responsibility for making their own decisions. These decisions should be based upon accurate information and an awareness of the various points of view and the pluralism of values which are possible in the area of human sexuality.

When presenting information for the teens to use in making their own decisions, care must be taken to present the information in a framework which is comprehensible to teenagers. As an illustration, consider the problem of communicating the consequences of childbearing to teens. Most adolescents are not self-supporting and have little awareness of the financial considerations. And with their generally shorter range future orientation it may be difficult for them to fully grasp that what is being discussed is a responsibility which will last as long as their entire past lifetime.

Equally as important as the presentation of accurate factual information, and perhaps even more difficult, is discussion of the psychosocial aspects of human sexuality. Because our own values have a somewhat insidious way of appearing as facts to us, it is necessary

to stand outside one's own personal value system in order to promote full discussion of all points of view. But this is precisely what is needed if the teens are to work through their own feelings concerning their sexuality. If they do not achieve an acceptance of sex as a normal and natural part of life and of themselves as sexual beings, there is no reason to believe that they will use the factual information they learn, such as about contraception, because they will not see it as applying to themselves.

The discussion thus far has been phrased primarily in terms of sex education programs. However, the content of the discussion is equally applicable to other aspects of total sexual health care such as the provision of contraceptive services. The vast majority of people of any age don't become contraceptors because of general demographic concerns. Rather, fertility regulation is practiced when individual self-interest is served. It is for this reason that teenagers should be represented in the planning and implementation of programs designed to serve them.

In addition to obtaining teen input by surveying its clientele, the Detroit program also utilized a Teen Advisory Board as a source of information and as a means of increasing staff-patient communication and understanding. The Teen Advisory Board helped formulate policy and had a major role in interviewing and selecting the staff. This assured the selection of a staff which was sympathetic to the needs and concerns of the teenagers. An advisory board such as this also provides a direct means for the target population to express its opinions on the types of services they feel they need and the most appropriate way of providing those services.

The teen population can also be easily represented in the day-to-day operations of programs directed at them. In the case of the

Detroit clinic, this participation took the form of teen volunteers who were involved in various aspects of the program. Their activities ranged from carpeting the clinic with donated carpet samples to helping with client reception. The inclusion of teenagers in both the planning and operation of the clinic helped insure that the Teen Center provided the services the teens needed in a hospitable environment. If there is one thing which we have learned over the years, it is that programs which alienate the people they are supposed to serve will not be utilized, no matter how good the intentions of the program organizers.

In concluding this discussion, I would like to reiterate several points which indicate the desirability of involving adolescents in education and health care planning. First, without such teen representation, adults tend to lack an awareness of teenagers' needs for sex education and sexual health care services. The negative consequences of not serving these needs are well-documented.

A second important consideration is that without teen input there is less chance that the sex education and health care programs will be tailored to fit the target population. The data from the Detroit program which I have presented and published are useful for making people aware of teenagers' needs for sex education and contraceptive health care. These data can form a basis for beginning program planning but they should be strengthened with input from the specific target population the program is intended to serve.

And third, getting teen health consumers involved in program planning and operation by giving them meaningful responsibility is important to their growth and development. Individuals must be given the opportunity to learn to handle responsibility -- this knowledge is not acquired automatically as a function of aging. It is hoped

that increased representation of teenagers in the planning process will improve the quality of sex education and health care programs available to them to the point where the current situation will be reversed so that the majority of sexually active teenagers will not have engaged in intercourse without using contraception because of inaccurate knowledge or difficulty in obtaining birth control (cf. Shah, Zelnik & Kantner, 1975).

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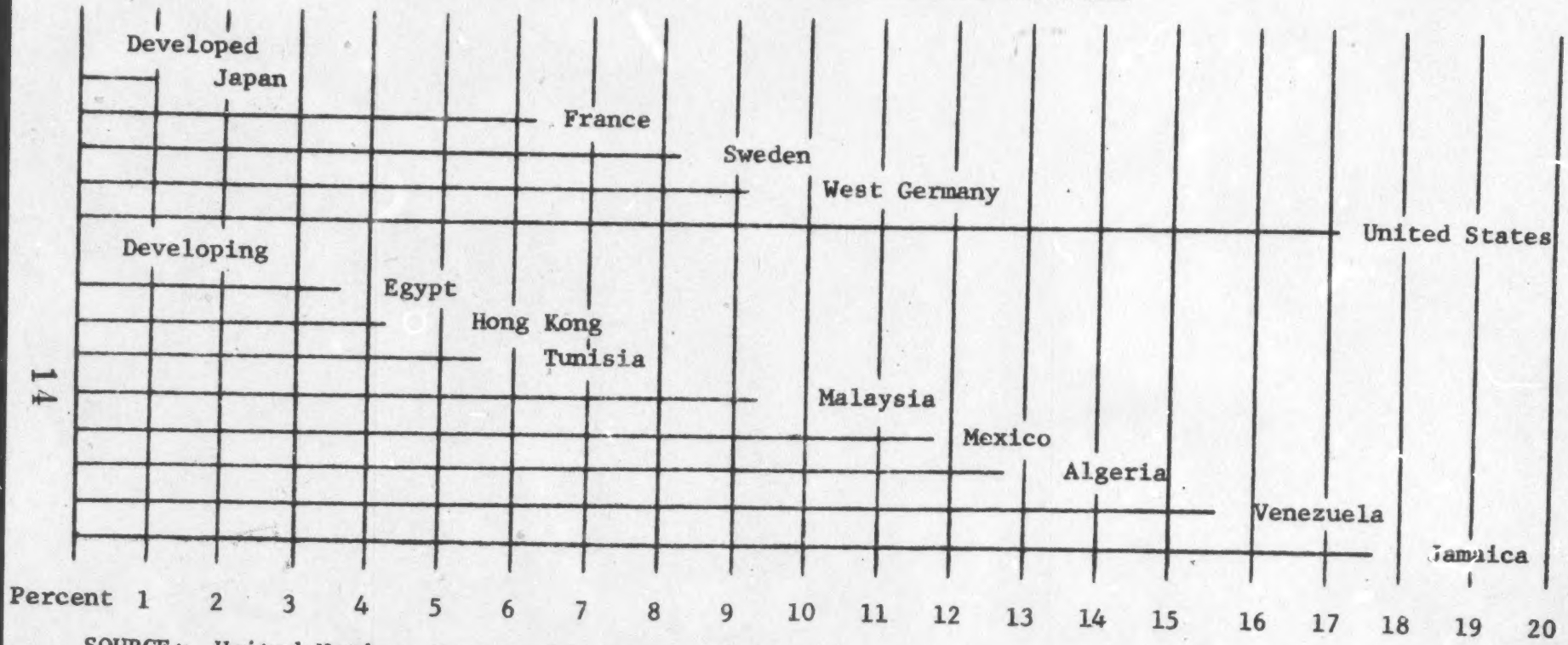
FIGURE 1

PERCENT OF TOTAL LIVE BIRTHS TO WOMEN AGED 15-19 FOR SELECTED COUNTRIES



SOURCE: United Nations Demographic Yearbook, 1972

Table 1

Responses of Teenagers to Statements on Human Sexuality (N=1190)

Questionnaire Item	True %	False %	Don't Know %
The man should begin sex play.	30	45	25
There is too much emphasis upon sex in our society by advertisements, movies, TV, etc.	35	48	17
Girls are often talked into having sexual relations when they really don't want to.	49	40	12
It is a mark against a person to be a virgin these days.	5	90	5
A lot of people start having sex because it is "the thing to do" in a relationship.	41	49	10
A girl stops being a virgin only after a man's penis has penetrated her vagina.	61	26	14
Most men still want their brides to be virgins.	30	40	30
Most men feel threatened by women who have had previous sexual experience.	22	47	31

Note: Percents may not add to 100 due to rounding.

Table 2

Responses of Teenagers to Statements
on Oral-Genital Sex
(N=1190)

Questionnaire Item	True %	False %	Don't Know %
Oral-genital sex is unnatural	8	72	20
Oral-genital sex is a common practice.	56	10	34
Oral-genital sex is unhealthy physically or mentally.	9	61	30
Guys like to have oral-genital sex done to them more than they like to do it.	29	24	48
Girls feel self-conscious or uncomfortable about having oral-genital sex.	34	29	37
I <u>have never</u> engaged in oral-genital sex.	41	55	4
I <u>probably will</u> engage in oral-genital sex sometime in the future.	59	20	21

Note: Percents may not add to 100 due to rounding.